B.5 Benefits and Services

"The nature of chronic illness requires a comprehensive, care coordination-based approach that utilizes a variety of interventions which change over time and which contain both a clinical and non-clinical component."[1]

The California Community Transitions demonstration will make use of a comprehensive service plan (CSP) as the focal point of transition services. Assessment of a demonstration participant's preferences and needs allow development of a support system that will help ensure his/her health and safety immediately after transition and for the long term.

The CSP is comprised of seven service areas which create the foundation for a successful transition: health care, supportive, social, environmental, education/training, financial and other services. Not all of these are Medi-Cal services, but are necessary to provide the support for a safe community environment based on each participant's unique needs and circle of community supports.

The comprehensive service plan details participants':

Health Care Services
- Plan of treatment
- Nursing care services
- Nutrition services
- Allied health and therapies
- Durable medical equipment and supplies

Supportive Services
- Family and friends
- Personal attendants
- Emergency back-Up
- Housing
- Transportation

Social Services
- Peer support and mentoring
- Recreational, cultural and spiritual connections

Environmental Services
- Home and vehicle adaptation
- Assistive technology
- Household set-up

Education and Training Services
- Independent living skills and life skills development
- Caregiver training and management
- Emergency planning

Financial Services
- Medi-Cal codes
- Money management
- SSI/SSP payments

Other Services
- Demonstration
- Supplemental

Combined, these services provide the support for a safe community environment based on each beneficiary's unique needs and circle of community supports.

[1] Testimony (pp3-4) by George A. Taler, MD, Director of Long-Term Care at Washington Hospital Center, 2/25/03, before the House Ways and Means, Health Subcommittee Hearing on Eliminating Barriers to Chronic Care and Care Management in Medicare on behalf of the American Geriatrics Society.

The comprehensive service plan is more than paper in a participant's chart and more than just a medical plan of treatment. It is a living document that will be revised in response to changes in a participant's health status and situational needs. Periodic re-assessment of demonstration participants' needs and preferences will take place during the 365-day participation in the demonstration to accommodate ongoing needs. This allows development of a support system that will ensure his/her health and safety immediately after transition and in the long-term. Documentation of numerous studies show that poor care coordination and lack of beneficiary support after discharge can lead to poor health outcomes, such as repeated hospitalizations, serious illnesses, re-institutionalizations, and even death.

California's Service Planning Models and Delivery Systems

Currently, the state has multiple service planning models under an array of approved Medi-Cal waivers and Medi-Cal state plan services. The state uses multiple assessment tools, some of which have not been validated for use across subpopulation groups. Most of the existing assessment tools and service planning protocols are designed for diversion from inpatient facilities and do not include coordination of housing searches and other necessary components of an individual's plan to transition to the community. Most are focused on a single or limited subpopulation or a limited scope of services instead of taking into account any of Medi-Cal HCBS services that have been approved and the non-Medi-Cal community supports such as affordable housing, income maintenance and transportation.

The transition coordinator is responsible for connecting demonstration participants with appropriate providers and community resources that can address their unique needs and preferences. Transition coordinators establish a one-on-one relationship with the participant and will work with the individual to come up with a comprehensive service plan to maximize independence, dignity, health, and safety. Some of the state's service delivery models are connected to ongoing Medi-Cal services and supports in the community through HCBS waivers, but some are not; for example, independent living centers do not currently rely on Medi-Cal financing.

The state's goal in implementing this demonstration is to identify best practices, and to establish successful models that can be replicated to successfully support an individual's preference to relocate from an inpatient facility back to community living. Utilizing the state's existing Medi-Cal provider networks during the demonstration to deliver state plan and HCBS waiver services, the state will be identifying opportunities to build on local networks and local investments in single points of entry (including Aging and Disability Resource Centers/Connection programs and "no wrong door"), successful assessment procedures, and effective consumer education strategies for connecting individuals and their treating professionals to home and community-based alternatives to inpatient facility stays. The state will highlight the designated regions as starting points, and build during the demonstration and beyond, will build on the models to create and replicate best practices.

DHCS' Relationship with Lead Organizations on Transition Process

As part of the single state Medicaid (Med-Cal) agency the Long-Term Care Division will oversee the California Community Transitions demonstration. Forming a unique partnership, DHCS is working with lead organizations in various regions of the state. The four lead organizations contracted with DHCS to work on the CCT demonstration have been transitioning residents to the community during the past several years without the use of waiver services. The project team will learn how they have succeeded, and at the same time, train the lead organizations and regional transition teams on the demonstration protocols. In addition, the project nurse will work with the transition coordinators and transition team members, who may also be employed by the lead organization, to provide resource information on available services.

Prior to partnering and contracting with DHCS, the four lead organizations worked with local inpatient facility staff when a resident requested information regarding living in the community. Under the CCT, this process will change. Once trained in the CCT eligibility requirements, the lead organization will conduct Preference Interviews with potential residents and discuss available community service options. Once a stable preference has been determined, the resident will be enrolled in the demonstration and will assist with development of his/her comprehensive service plan.

Transition Coordination

As Medi-Cal providers, lead organizations will have the opportunity to directly provide or subcontract transition coordination services. Transition coordinators will work with demonstration participants to develop a comprehensive service plan to ensure the participant is provided needed health, social and supportive services after discharge from a facility.

Initially, the transition coordinator is designated as having "lead responsibility" for oversight of the comprehensive service plan. The designation of lead responsibilities should not be misconstrued to undermine the participant's rights, desires, and abilities to self-direct and coordinate his or her own services. Demonstration participants will be the decision-maker and will collaborate with the service coordinator or person offering peer support during the entire period of participation in the demonstration.

When demonstration participants choose the services they would like to receive, the transition coordinator will assist the participant in completing and submitting the appropriate application(s). The approval process for a Medi-Cal waiver is as follows:

- Assessing skilled care needs (medical, nursing and other allied health disciplines) involves reviewing nursing care records, speaking with the applicant, and performing a nursing assessment.
- Determining level of care (LOC) involves calculating the types of health care professionals and number of hours needed to provide care/services. These findings, based on the assessment of skilled care needs, with input from the participant and

primary care provider, are matched to the criteria set forth in California Code of Regulations, Title 22.

- Creating a comprehensive service plan (CSP) is the foundation of the transition process. If a participant needs health care services, a health care plan of treatment (POT) will be created using the information from the assessment of skilled care needs and the level of care determination. Medical care orders are determined by the physician, and the POT is signed by the participant, primary caregiver, and all health care providers. The CSP then becomes the document to be used when comparing quality of health care services and participant's health status.
- Ascertaining non-health care services needed involves exploring other necessary non-health care services and supports.

Traditionally, the review of non-health care services in the POT has consisted of a limited number of options such as personal care assistant, personal emergency response services, and brief health care education. This type of plan, based on the medical model, is not enough for persons transitioning out inpatient facilities after a stay of six months or more. Much is needed to assist both the participant and their support group to make the transition successful. Non-traditional areas relating to independent living need to be considered as well. As a result, a comprehensive service plan, which includes the POT, will be developed to review all areas affecting community living. This comprehensive service plan becomes the foundation of the transition process.

Once the participant has been transitioned to the community, the waiver case manager and/or state plan services manager (service coordinator) will assume responsibility in partnership with the participant for monitoring of the plan. The transition coordinator will "hand-off" lead responsibility for service coordination to the ongoing service coordinator on day one (day of discharge) of an individual's transition to the community. Both coordinators will work together during the first two months to assure needed services continue to be provided.

During the first two months after the date of transition, the HCBS waiver case manager and transition coordinator will work with the participant to evaluate the effectiveness of the existing comprehensive service plan. A transition team member will contact participants weekly during the first month to ensure they are receiving services as planned and address any issues that may arise. Then a transition team member will phone monthly to discuss ongoing services. They will speak with the participant, the caregiver(s), and support staff to determine if changes need to be made in the delivery of services. In addition, an assessment of participant's health status will be obtained from the nursing and/or medical provider and a check of 24/7 personal emergency response system use will be made. The transition coordinator and HCBS service coordinator will consult regarding the findings, and together, may recommend changes to the comprehensive service plan. Together the participant, transition coordinator, and waiver/service case manager will modify the plan as needed. In addition, the CCT project nurse will be a resource to both the transition coordinator and the HCBS service coordinator or peer mentor throughout the 12 months of the demonstration.

Target Population Groups

The CCT demonstration targets persons who have been residents of inpatient facilities continuously for six calendar months or longer. The assumption is that, since beneficiaries are living in an inpatient facility, they have skilled care and service needs and are thereby eligible to enroll in a waiver. In addition, the assumption is that all initial evaluations (PASRR Levels 1 and 2, as needed for persons with mental health diagnoses and CDER for persons with developmental disabilities) and diagnosis classification will have been completed prior to conducting a Preference Interview.

1. Pre-Admission Screening & Resident Review (PASRR)

   Federal Medicaid regulations require states to maintain a PASRR program to screen nursing facility applicants and residents for serious mental illness, developmental disability, or other relation condition. All Medi-Cal-certified nursing facilities are responsible for initiating a Level 1 PASRR evaluation for new applicants and for any current resident who experiences a significant change in physical or mental condition. PASRR is a two-level screening process designed to determine:
   - Whether a nursing facility care is required.
   - Whether nursing facility level of care is the least restrictive environment in which care may be provided.
   - If nursing facility level of care is the least restrictive environment, are specialized services (active treatment) required?

   PASRR Level 1 is an identification screening process. Any person who has evidence of mental illness or developmental disability is evaluated again on a second level. PASRR Level 2, administered by local county mental health staff, is an evaluation to determine if specialized services and nursing facility services are needed. This portion is the responsibility of the mental health authority and the state Medicaid agency. If inpatient facility services are not needed, then the state may make other more appropriate living arrangements. Information is available at http://download.ncadi.samhsa.gov/ken/pdf/SMA05-4039/SMA05-4039.pdf.

2. Client Development and Evaluation Report (CDER)

   Administered by California Regional Centers and Developmental Centers, the Client Development and Evaluation Report (CDER) is the assessment instrument used to collect data on two areas:

   - Consumer diagnostic characteristics, and
   - Consumer evaluation of current status in development in present living situation covering level of skill in tasks necessary for daily living, personal outcomes, physical and social environment, health and safety, and challenging behaviors.

Additional information can be downloaded from the California Department of Developmental Services website at http://www.dds.cahwnet.gov/.

California Community Transitions Screening

The CCT demonstration establishes a much more comprehensive screening process in addition to the PASRR Level 2 screens. Transition teams conduct one-on-one Preference Interviews with facility residents in the following populations:

- Elders with one or more medical, functional, or cognitive disability.
- Persons with developmental disabilities.
- Persons with one or more physical disabilities.
- Persons with mental illness.
- Persons with dual diagnoses.

Stakeholders requested that the demonstration also target the following populations:

- Persons with acquired/traumatic brain injury
- Adults/Children who are hard-to-place.

When transitioned, data describing these last two subpopulations will be included and reported to CMS under the physical disability, mental illness, or dual diagnoses federal categories.

HCBS Waivers and Programs

Under existing law, DHCS administers or monitors a wide array of Medi-Cal HCBS waivers enabling Medi-Cal recipients to utilize necessary services in community settings instead of receiving services in inpatient facilities. Currently HCBS waivers have capacity for demonstration participants. Within six months of implementation of CCT, DHCS will have compared service coverage across all existing Medi-Cal HCBS waivers and will have analyzed any need for additional coverage or capacity. Upon completion of this analysis, DHCS will seek amendments to applicable waivers.

The project nurse's role is to ensure participants are enrolled in the appropriate waiver, as determined by their skilled care and service needs. For the remainder of calendar year 2008, when eligible, demonstration participants will be enrolled in the NF/AH waiver. It is offered statewide, and has been providing services for many beneficiaries since January 1, 2007.

Waiver Services

The state will receive an enhanced Federal Medical Assistance Percentage for provision of QHCBS for 12 months while participants remain in the CCT demonstration.

When a resident transitions from a facility, the state's goal is to provide the most appropriate waiver and/or state plan service(s) to meet the needs of his/her comprehensive service plan. Transition teams will work with potential participants to design their comprehensive service plans based on their skilled care needs and service requests (see steps 5-8 of the general transition process for the demonstration found in Section B.1, page 45). Transition coordinators will then consult with the CCT project nurse regarding application and enrollment into the appropriate waiver or state plan program, and creation of a menu of health services (MOHS) for discussion and approval by participants. The participant then will determine his/her choice of waiver, and which service agencies to use, unless there is a specific agency required by the CCT demonstration for a particular service.

California currently has the following approved waivers (refer to Appendices V and XI for additional information on services provided under each):

- 1915(b) Freedom of Choice Waiver
  - Specialty Mental Health Consolidation Program

- 1915(c) Home and Community-Based Services (HCBS) Waivers
  - Acquired Immune Deficiency Syndrome (AIDS)
  - Assisted Living Waiver Pilot Project (ALWPP)
  - HCBS Waiver for the Developmentally Disabled (DD Waiver)
  - Multipurpose Senior Services Program (MSSP)
  - Nursing Facility/Acute Hospital (NF/AH)

- 1115 Demonstration Project Waiver
  - In-Home Support Services Plus (IHSS Plus)

Initially, CCT participants will not be enrolled into the County Organized Health Systems 1915(b) Freedom of Choice Waivers referenced in Appendix V, nor will they have the option of enrolling into the Program of All-Inclusive Care for the Elderly (PACE) at this time. While the programs may be appropriate HCBS for some of the targeted populations, HCBS codes and rates are not readily available for federal reporting purposes under the MFP Rebalancing Demonstration. DHCS will work with programs and plans to establish an acceptable methodology to capture expenditures and seek CMS' approval before these waivers can be a resource to participants.

The state is currently seeking approval from CMS to implement two additional 1915(c) waivers:

- Pediatric Palliative Care Waiver
- Self-Directed Services/Developmental Disabilities Waiver

Once approved, DHCS will seek CMS' approval to offer these as resource to participants.

State Plan Services

California offers many Medi-Cal state plan optional benefits. The state will continue to receive regular FMAP for provision of these services to demonstration participants:

1. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program – applies only to full-scope eligible persons under 21 years of age.
2. Supportive services: Sign language interpretation
3. Prevention and health teaching, e.g., smoking cessation
4. Prosthetic and orthotic appliances
5. Durable medical supplies and equipment – purchase and/or rental
6. Non-emergency medical transportation
7. Mental health services
8. Medical supplies (includes incontinence supplies)
9. Oxygen
10. Ventilator (rental)
11. Other more commonly utilized services not billed through a home health agency, such as physician; dentist; outpatient clinic services such as dialysis and wound care clinics; physical, occupational, or speech therapy; acupuncture; family therapy; and MSW services.

As discussed in Benchmark #2, section A.2, page 25, the state will receive enhanced FMAP for providing the following optional state plan benefits to demonstration participants:

1. Adult Day Health Care services
   ADHC centers offer health, therapeutic and social services in a community-based day health care program. Services are provided according to a six-month plan of care developed by the ADHC's multidisciplinary team. The services are designed to keep recipients as independent as possible in a community setting.

2. Home Health Agency services
   Intermittent skilled nursing care services provided through home health agencies: registered nurse; licensed vocational nurse; licensed therapist (physical, occupational and speech); social worker; home health aide; psychology services; infusion services; and medical supplies, equipment and appliances.

3. Personal Care Services
   Personal care service is an optional Medi-Cal benefit provided in every county of the state. The Personal Care Services Program (PCS) is generally referred to as In-Home Supportive Services (IHSS). PCS is an entitlement with no enrollment cap for all eligible beneficiaries who are at risk for placement in an inpatient facility because they are unable to remain safely in their own home without assistance. Services offered include domestic and related tasks such as laundry, shopping, meal preparation, light housecleaning; personal care services such as assistance with eating, bathing, and walking or moving from one place to another; transportation to and from medical appointments; and certain paramedical services ordered by a

physician. Currently, county staff members determine a beneficiaries' program eligibility, the number of hours, and type of services approved to meet each individuals' needs. The maximum number of monthly PCS hours that can be authorized is 283 hours.

The supply of trained personal care services providers has grown over the past few years as the demand for their services has increased. With the expansion of the IHSS and IHSS Plus Services, more opportunity is provided for eligible, qualified individuals (including participants' family members and friends) to be hired, trained and serve as personal care workers.

The self-direction focus of IHSS Plus gives beneficiaries of IHSS the ability to hire people who might otherwise be giving care as a volunteer, thus contributing somewhat to an expansion of the workforce. Additionally, these personal attendants receive training which may become a billable skill of their own.

Demonstration Services

DHCS engaged stakeholders in initial discussions about potential demonstration and supplemental services in August 2007. The following services were identified as being important for a successful transition:

- Independent Living Coach Services
- Expanded/Updated Assistive Technology
- Attendant/Accompaniment during Medical Appointments
- Individualized Informal Caregiver Training
- Peer Mentoring
- Orientation to mobility adaptations (for blindness, deafness, amputation, etc.)
- Pet attendant set-up and owner training
- Modifications to a vehicle
- Adaptable clothing set-up
- Disaster preparedness supplies/accommodated first aid kits
- Fall prevention-modified environment (e.g., furniture moving, floor covering modifications, etc.)
- Home set-up
- Social network re-connect (social worker and/or peer mentor)

As previously stated in the Introduction (page 6), several of the state's working priorities for California Community Transitions include expanding or enhancing existing Medi-Cal waiver service definitions, gaining experience with successful transitions, and developing new HCBS policy based on experience. Through the lessons learned from the delivery of demonstration services, DHCS seeks to improve California's multiple, population-based waivers.

In addition to commonly used services targeted to different populations in each waiver, seven demonstration services will be made available on a limited basis to all

demonstration participants. Provision of these services is based on individual need, primarily during the first year of their transition, with the goal of helping them re-establish a safe home and integrate well into their communities. Provision of demonstration services will be based on participant need which will be documented in his or her comprehensive service plan.

The demonstration services are as follows:

1. Transition Coordination
2. Home Set-Up
3. Home Modification
4. Habilitation
5. Family and Informal Caregiver Training
6. Vehicle Adaptations
7. Assistive Devices

These services—or similar services—may or may not currently be offered in the different HCBS waivers. Historically, waiver services in California have been defined with diversion in mind; that is, helping beneficiaries stay in a home in which they already live. The existing waiver services may not be adequate in scope or duration for a population transitioning from a facility after a lengthy stay of six months or longer. These individuals may have critically different needs at the initial service planning stage and first months of service initiation from persons who are already in, or moving back to, the community after brief stays in institutional settings. The current waiver services available in California were designed for those individuals and not the MFP target population. Most, if not all, of the MFP population have lost support from family and/or other human service networks. Their linkages to housing, family supports and other supportive community services are so compromised or nonexistent that they predictably need help to establish new living arrangements and social networks—to their church or synagogue, neighborhood grocer or market, recreational activities, families and friends. The demonstration services are designed to support MFP participants as they reenter their communities.

When a participant's demonstration period ends (365 days), these services will no longer be provided because participants will not need them. They will have transitioned into qualified residences, purchased needed household items and assistive devices, secured paid and/or unpaid caregivers and health care providers, and received training and support to acclimate to the community during the twelve months the demonstration services are available.

The grid in Appendix XI shows the HCBS services in the California State Plan and existing waivers that are available to demonstration participants. Receipt of demonstration services in addition to available state plan and waiver services will ensure that participants have a successful start on living independently while building their self confidence and adjusting to an effective and efficient mix of government-funded services and informal support networks.

Demonstration services will be included in each participant's comprehensive service plan, but will not be included in the computation of waiver cost neutrality. The project team will track and report utilization of demonstration services separately from QHCBS.

Demonstration Service	Service Description	Service Boundaries[2]	Code	Rate Range
Transition Coordination	One-on-one liaison among a participant, inpatient facility, and lead organization responsible for the assessment and planning process, and implementation of the comprehensive service plan before, during, and two months after transition from a facility. Service is approved in 3 waivers (NF/AH, MSSP & ALWPP).	1. If covered under an existing waiver chosen by the participant, the demonstration service provides for service provision in addition to that covered in the waiver[3], to a total not to exceed 100 hours. 2. If not covered under the existing waiver chosen by the participant, the demonstration service is provided up to a limit of 100 hours.	G9012	$35.77 per hour for individual providers. $45.43 per hour for agency providers. These are the rates used in the NF/AH waiver.
Home Set-Up	Non-recurring set-up expenses for goods and services identified in an individual comprehensive service plan for a demonstration participant who is directly responsible for his or her own living expenses. Service is approved in 3 waivers (NF/AH, ALWPP & DD).	1. If covered under an existing waiver chosen by the participant, the demonstration service covers the difference between what is covered under the waiver and the identified need not to exceed $7,500. 2. If not covered under a waiver chosen by the participant, the demonstration service provides up to $7,500.	T2038	Cost up to $7,500.

[2] Prior-authorization is required by the demonstration project nurse.

[3] Ten hours is generally the time needed to transition residents who have been in a facility for a post-rehab or short stay and returning to a home in which they already live.

Demonstration Service	Service Description	Service Boundaries[2]	Code	Rate Range
Home Modification	Environmental adaptations to a participant's home identified in the comprehensive service plan, including, but not limited to, grab-bar and ramp installation; modifications to existing doorways and bathrooms; installation and removal of specialized electric and plumbing systems. Service is approved in 4 waivers (NF/AH, MSSP, ALWPP & DD).	1. If covered under an existing waiver chosen by the participant, the demonstration service covers the difference between what is covered under the waiver and the identified need, not to exceed $7,500. 2. If not covered under a waiver chosen by the participant, the demonstration service provides up to $7,500.	S5165	Cost up to $7,500.
Habilitation	Coaching and life skills development on how to build and manage relationships, and other training needed for the participant to learn, improve, or retain adaptive, self-advocacy, or social skills, as identified in the comprehensive service plan. Ensures success and quality of life in the community. Service is approved in 4 waivers (NF/AH, MSSP, ALWPP & DD).	1. If covered under an existing waiver chosen by the participant, the demonstration service provides for service provision in addition to that covered in the waiver[4], not to exceed a total of 50 hours. 2. If not covered under a waiver chosen by the participant, the demonstration service provides for up to 50 hours.	T2017	$8.94 per 15 minute increments for an individual provider. $11.36 per 15-minute increments for an agency provider. These are the rates used in the NF/AH waiver.

[4] Ten hours is generally the time needed to provide habilitation/life skills training to persons who are being diverted from LTC facility placement and returning to a home in which they already live.

Demonstration Service	Service Description	Service Boundaries[2]	Code	Rate Range
Family and Informal Caregiver Training	One-on-one individually tailored sessions conducted in person or electronically by an approved trainer, to assist caregivers in developing the skills and gaining the knowledge they need to enhance a participant's health, nutrition, and/or financial literacy. Examples include, but are not limited to, daily care management, fall prevention, coping skills, emergency response and long-term care planning.	1. If covered under an existing waiver chosen by the participant, the demonstration service provides for service provision in addition to that covered by the waiver[5], not to exceed 50 hours. 2. If not covered under a waiver chosen by the participant, the demonstration service provides for up to 50 hours.	S5111	$45.43 per 1-hour session. This is the rate used in the NF/AH waiver.
Vehicle Adaptations	Devices and controls required to enable demonstration participants and/or family members and caregivers to transport participants in their own vehicles. It must be documented in the comprehensive service plan how these items will sustain participants' independence or physical safety, and allow them to live in their homes. Includes but is not limited to installation and training in the care and use of these items.	1. If covered under an existing waiver chosen by the participant, the demonstration service covers the difference between what is authorized under the waiver and the identified need, not to exceed $12,000. 2. If not covered under a waiver chosen by the participant, the demonstration service provides for up to $12,000. Approval is contingent on denial from all other potential funding sources.	Z9110 (from DD waiver)	Cost not to exceed $12,000.

[5] Four hours is generally the time needed to train caregivers to assist persons who are being diverted from LTC facility placement and returning to a home in which they already live.

Demonstration Service	Service Description	Service Boundaries[2]	Code	Rate Range
Assistive Devices	Adaptive equipment designed to accommodate a participant's functional limitations and promote independence, including, but not limited to, lift chairs, stair lifts, diabetic shoes, and adaptations to personal computers. The need for items must be documented in the comprehensive service plan with an explanation of how they would prevent elevation to a higher level of care or return to an inpatient facility.	1. If covered under an existing waiver chosen by the participant, the demonstration service covers the difference between what is covered under the waiver and the identified need, not to exceed $7,500. 2. If not covered under a waiver chosen by the participant, the demonstration service provides for up to $7,500. Approval is contingent on denial from all other potential funding sources.	Z0922, Z9023, Z9043, Z9065 (from DD waiver)	Cost not to exceed $7500.

No supplemental services are proposed at this time.

The Strategy Grid on page 7 of this Protocol gives a snapshot of the state's strategy for establishing new waiver and state plan services. The project team will continue to work with stakeholders to analyze differences in existing HCBS and state plan services, evaluate findings, assess the significance of service provision, and make recommendations for provision of additional services for the benefit of all Medi-Cal beneficiaries.

Services listed by Population Group

Appendix XI is an exhibit of waiver and state plan services available to demonstration participants, and the target populations which may be served under each waiver.

Managed Care Services

As previously stated, initially, CCT participants will not be enrolled into the County Organized Health Systems 1915(b) Freedom of Choice Waivers referenced in Appendix V, nor will they have the option of enrolling into the Program of All-Inclusive Care for the Elderly (PACE) at this time. DHCS must first work with programs and plans to establish an acceptable methodology to capture expenditures and obtain CMS' approval before these programs can be a resource to participants. They are discussed below **for informational purposes only**.

Medi-Cal Managed Care Plan Services

Comprehensive and Integrated Managed Care – Three models of comprehensive managed care are available to seniors and persons with disabilities in California. They are the Program of All-Inclusive Care for the Elderly (PACE), authorized under state plan Amendment No. 02-003; the Senior Care Action Network (SCAN), currently an 1115 waiver through January 1, 2008, and County Organized Health Systems (COHS) which operate under a 1915(b) Freedom of Choice waiver to administer a capitated, comprehensive, case managed health care delivery system. If the individual is interested in comprehensive managed care, the transition coordinator will investigate whether PACE, SCAN or a COHS is available in the area. If the service is available, the transition coordinator will ensure, as appropriate, that demonstration participants will be enrolled into programs that ensure continuity of care, meet the demonstration requirements and accomplish the purposes of the demonstration.

1. The Programs for All-Inclusive Care of the Elderly, or PACE program [state plan amendment no. 02-003], offers and manages all medical, social, and long-term care services that enrollees require to preserve or restore their independence, to remain in their homes and communities, and to maintain their quality of life. One of most notable features of the program is the PACE center which co-locates a primary care clinic and an adult day health care center as the primary means of delivering the full range of medical and long-term care services to enrollees. At the heart of the model is the interdisciplinary team, consisting of professional and paraprofessional staff who assess enrollee's needs, develop care/service plans, and deliver and arrange for services, which are integrated for a seamless provision of total care.

   Individuals must be 55 years of age or older to enroll in PACE, live within the program service area, meet California's criteria for nursing home level of care and be able to live safely in the community without jeopardizing his or her health and safety. PACE programs receive a monthly capitated payment from Medicare and Medi-Cal for all eligible enrollees. Currently, these programs are operational in four counties: Los Angeles, Sacramento, Alameda, and San Francisco.

2. The Senior Care Action Network, or SCAN health plan [a section 1115 demonstration being converted to an ongoing state contract under section 1915(a)], and has grown in the social health maintenance organization (S/HMO) model, expanding coverage for community-based long-term care and is designed to keep older adults who have one or more functional impairments living at home as long as possible. The program integrates medical, social and long-term care services and merges the HMO concepts of capitation, financing and provider risk sharing with the case management and support services concepts of long-term care providers. SCAN offers a comprehensive senior health plan that includes routine physicals, hearing exams, and prescription drug coverage. It also includes personal care services which range from light cleaning to transportation and escorts to members who are eligible for nursing home placement. A modest amount of nursing home

care is added, in a controlled manner, and these services are linked as part of a complete medical care system.

Individuals must be 65 years of age or over and eligible for Medicare Part A&B. SCAN is one of the original demonstration sites and has been operating since 1985. From its headquarters located in Long Beach, SCAN serves individuals who reside in certain areas of Los Angeles, Riverside and San Bernardino counties. CMS and DHCS hold contracts to provide services to Medicare and Medi-Cal members.

3. CalOptima, a 1915(b) waiver, is one of five County Organized Health Systems (COHS) – Health Insuring Organizations of California (HIO) with a long history of commitment to developing home and community-based supports to enhance the delivery of care across the continuum for the state's most vulnerable population. CalOptima has worked toward an integrated care model by adding on a Multi-Purpose Senior Services Program (MSSP) waiver population, Cal-Optima recently launched a Medicare Advantage Special Needs Plan, called OneCare, to serve dually eligible members living in Orange County.